Seymour House (Hartlepool) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Seymour House (Hartlepool) Limited provides nursing and residential care for up to 20 people. The home provides care and support for people with mental health needs. At the time of this inspection there were 20 people living at Seymour House (Hartlepool) Limited.

This was an unannounced inspection. During this inspection we looked at all 23 key lines of enquiry (KLOEs). We spoke with nine people who lived in the

Summary of findings

home, four staff and the registered manager of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We spoke with nine people, looked at the care records for six people and looked at records that related to how the home was managed.

We last inspected Seymour House (Hartlepool) Limited in May 2013. At that inspection we found the service was meeting all the regulations that we inspected.

People's needs had not been fully assessed following their admission into the home. We also found that care plans were not written in a person-centred way and used language that people would find difficult to understand. Care plans did not evidence that people had been involved in developing them. The registered manager told us that they were already implementing a new format for care planning which would be more person centred.

Care plans we viewed contained limited information to guide staff about the most effective care to meet people's needs. For example, to 'liaise with health professionals' and 'give medications.' Progress towards achieving outcomes was difficult to measure due to the way care plans had been written. People's care records were not recorded in line with recognised best practice.

The home's approach to managing on-going risks was unclear. The provider had access to referral information about each person, including any potential risks. However, we found no evidence of a risk assessment tool that Seymour House staff would use to assess risks from the point of admission onwards.

We found that the service had clear expectations about how people should be treated. These had been documented into an 'Expectation Card' and made available to people who used the service. People said they felt safe living at the home and felt comfortable approaching staff if they had any worries or concerns. People told us they were treated equally and fairly.

Staff we spoke with had a good understanding of the needs of the people they were caring for. They also had a good understanding of how to keep people safe and knew how to respond to safeguarding concerns and behaviours that challenge. Staff told us they were well supported to carry out their caring role and could approach the manager with any concerns they had.

Staff told us that people in the home were currently able to make their own decisions. They understood when the Mental Capacity Act 2005 (MCA) may apply to people and how to respond should there be doubts about a person's capacity to make decisions. Following the Supreme Court judgement about what constitutes a Deprivation of Liberty, the registered manager was in the process of assessing each person to determine whether a DoLS application to the local authority was required. So far no DoLS applications had been needed.

Most people who used the service felt there were enough staff to meet their needs in a timely manner. The registered manager told us that staffing levels were flexible and determined by people's needs. The registered manager reviewed staffing levels as part of a six monthly quality assurance programme.

The provider had policies and procedures to ensure people received their medication from trained staff and in a timely manner. However, the service did not have an effective system to identify and investigate gaps in medication records. The registered manager carried out a range of checks to make sure the premises were safe, well maintained and clean.

People told us they felt the staff providing their care had the appropriate experience and skills. They said staff looked like they knew what they were doing.

Staff carried out routine checks of people's health and supported them to attend appointments or if they needed to go to hospital. One person confirmed that staff supported them to attend the hospital every few months. However, we found no evidence that planned therapeutic interventions were taking place, such as group work, relaxation therapy and anxiety management.

People were supported to meet their nutritional needs. People were assessed for the risk of poor nutrition. Staff said that there was currently nobody identified as at risk. Staff had a good understanding of people's food likes and dislikes and ensured that they were offered things they liked to encourage them to eat. People were happy with the food they received and gave us only positive comments.

Summary of findings

People said they were well cared for and that staff treated them well. They also said they were treated with dignity and respect. Staff described how they maintained people's privacy and dignity and gave us practical examples of how they delivered care to achieve this aim. We observed that there were positive interactions and a good rapport between staff and people. Staff told us that they spent one to one time with people sitting and chatting, looking through newspapers, shopping or sorting out clothes and toiletries.

People were supported to maintain their independence. We saw that people accessed the local community independently and were encouraged to do things for themselves.

People had opportunities to give their views about the service through regular meetings and questionnaires. We found staff listened to people's views and responded to their suggestions.

People were asked for their consent before receiving any care and support. They had the opportunity to be involved in a range of activities, such as trips out, the walking club, visiting family, card games, board games and entertainers.

There had been no complaints made about the service. However, there were systems in place to deal with any complaints received. People told us they were happy with their care and nobody raised any concerns or complaints with us during our inspection.

The values of the service were not fully embedded into service delivery as staff were unable to confidently tell us what they were. The service had an over-arching five year plan, which included specific objectives which included providing a well-trained, skilled staff team and promoting excellence in care practices.

There was a clear management structure in the home and people and staff knew who to go to if they had any concerns. Staff had the opportunity to give their views about the service including any suggestions they had to improve the service.

People made mostly positive comments about the atmosphere in the home. One person told us that there could sometimes be a bit of tension between some of the people who used the service.

The provider carried out a range of checks and audits as part of a six monthly quality assurance programme. The registered manager was a visible presence around the home observing care delivery and speaking with people to encourage them to give feedback.

The provider had policies and procedures in place to respond to any whistle blowing concerns and staff were aware of their responsibilities. Staff said the manager would act immediately on any concerns. There were systems to log any incidents and accidents that happened at the service. We found from viewing the log that action had been taken following any incidents or accidents to keep people safe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. The provider did not have a clear approach to identifying, assessing and managing risks following a person's admission into the home. Staff had a good understanding of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People who currently used the service had capacity to make their own decisions and no DoLS applications were required.

People told us they felt safe and were comfortable approaching staff if they were worried or concerned. People also said they were treated equally and fairly.

Staff had a good understanding of safeguarding and managing behaviours that challenged the service. We found there were enough staff to meet people's needs in a timely manner. The service had procedures in place to ensure that people received their medication on time and to ensure that the premises were clean and safe.

Is the service effective?

Good

The service was effective. People told us they were cared for by knowledgeable and experienced staff. Staff had regular supervision and appraisal with their manager. They also had the opportunity to attend the training they needed to carry out their role effectively.

People were supported to meet their healthcare needs. Staff monitored people to ensure they remained healthy and supported people if they needed to go to hospital.

Staff assessed people for the risk of poor nutrition and knew how to care and support people who were at risk. People told us they were happy with the meals they were given.

Is the service caring?

Good

The service was caring. People gave us positive views about the care they received. They said the staff treated them with respect and they were well cared for. We saw that there were good relationships between staff and the people they cared for.

People were supported to be independent and described how they had made progress since moving into Seymour House.

People had access to information about advocacy services they could access if they needed independent advice.

Summary of findings

Is the service responsive?

Requires Improvement 

Some aspects of the service were not responsive. Care plans were written around the person's medical diagnosis rather than their presenting needs and how people's condition impacted on their every day needs. They were written in language that would be inaccessible to people who used the service. Staff told us that people were involved in developing their care plans. However, the care plans we viewed did not clearly evidence how people had been involved.

People had opportunities to give their views about the service through 'resident's meetings' and consultation. People were asked for their consent before receiving care. There were a range of activities for people to be involved in both inside the home and in the community.

The home had an effective complaints procedure. None of the people or family members we spoke with had made a complaint about the care they received.

Is the service well-led?

Good 

Overall the home was well-led. The home had a quality assurance programme to check on the quality of care provided.

The service's approach to dealing with gaps in medication records was unclear. The systems in place had not been successful in identifying an issue with a missing signature in one person's medication administration record.

Staff told us the registered manager was supportive and could be approached at any time for advice.

Seymour House (Hartlepool) Limited

Detailed findings

Background to this inspection

We inspected Seymour House (Hartlepool) Limited on 6 and 11 August 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection was carried out by an adult social care inspector, an expert by experience and a specialist advisor both with experience of care for people with mental health needs. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home, including the notifications we had received about safeguarding referrals made to the local authority. We also contacted the local authority commissioners for the service, the local healthwatch and the clinical commissioning group (CCG). We did not receive any information of concern from these organisations.

We spoke with nine people who used the service. We also spoke with the registered manager and four other members of care staff. We observed how staff interacted with people and looked at a range of care records which included the care records for five of the 20 people who used the service, medication records for the 20 people living in the home and recruitment records for six staff.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

The home's approach to managing risk was unclear. From viewing care records we saw that for most people a local authority care co-ordinator had completed a risk assessment which had been provided with other referral information on admission to the home. We found that when people were admitted to the service they were routinely assessed using standard assessments for poor nutrition, skin damage and moving and handling. However, we found no evidence of an individual risk assessment tool that Seymour House staff would use to assess risks from the point of admission onwards. For example, we saw that one person's care records stated that the person sometimes drank alcohol excessively. The person's activity support plan stated that the person visited the pub most days. However, we found no care plan or risk assessment relating to the safe use of alcohol and the potential detrimental impact of alcohol on the person's health.

People we spoke with told us they felt safe living at the home. People said, "I just feel safe", "At the moment I feel quite contented", and, "This is the only place I can say I've been contented." The registered manager said that locks on doors had been replaced and each person had their own key to their bedroom. This helped to promote their independence and have control over their living space. People told us they felt comfortable approaching staff if they had any worries or concerns. People said, "Yes, I would talk to the boss. I feel comfortable going to her", "Yes, but [I have] no worries or concerns", and, "The staff are always there to talk to."

Staff we spoke with had a good understanding of how to identify and respond to safeguarding concerns. Staff told us, and records confirmed, that they had completed safeguarding training which included testing their understanding of safeguarding. Staff were able to tell us about different types of abuse and could give examples of potential warning signs to look out for. For example, unexplained marks or bruising, becoming withdrawn, keeping away from other people who used the service or staff and differences in people's behaviour. Staff said that if they had any concerns they would report them to the registered manager or person in charge if they weren't available. The registered manager told us there had been no recent safeguarding concerns at the home. However, there were systems in place to log any safeguarding concerns received. The registered manager was aware of her responsibilities with regards to reporting concerns and the requirement to notify the Care Quality Commission where safeguarding issues were identified.

Staff had a good understanding of how to manage behaviours that challenged the service. They described the specific strategies they used, which were individual for each person. For example, talking to people, having time-out and spending time in the garden. Staff told us that restraint was not used at the service.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is a law that protects and supports people who do not have the ability to make decisions for themselves and to ensure that decisions are made in their 'best interests.' Staff told us that people in the home were currently able to make their own decisions. However they understood when the MCA could apply to people and how to respond should there be doubts about a person's capacity to make decisions. One staff member said, "You can't presume people haven't got capacity." We saw that information about the MCA had been displayed on the notice board for staff and people to refer to.

Staff followed the requirements of the Deprivation of Liberty Safeguards (DoLS). These are safeguards to ensure care does not place unlawful restrictions on people in care homes and hospitals. The registered manager was aware of the Supreme Court judgement to clarify what constitutes a deprivation of liberty. The registered manager had met with the local authority to discuss the implications of the judgement for people who used the service. We found that a new DoLS policy and procedure had been developed. The provider had also developed a checklist for staff to refer to so that they followed a consistent approach when considering whether a person was deprived of their liberty. At the time of our inspection the registered manager was in the process of reviewing each person to decide whether a DoLS application was required. So far no DoLS applications had been needed.

We found there were enough staff to meet people's needs. Most people said they felt there were enough staff on duty to meet their needs. They said they had their needs met quickly and did not have to wait for long. However, three people said that staff were often in a rush when approached. They said, "You sometimes have to wait to see staff"; "(Staff are) always in a rush"; and, "You really have to wait for a bath. Those who've been here longer get seen

Is the service safe?

earlier. Upstairs there's one bathroom for men and one for women. Only one shower room downstairs. There's a big strain on the shower room and the bathroom." We discussed this with the manager. She said people were able to have a bath when they wanted and it was not usually a problem. However, if the bathrooms were being used when a person wanted a bath or shower then they may have to wait for a few minutes until they were free.

The registered manager told us that staffing levels were responsive to people's care needs and that additional staff were deployed when required, such as when there were trips out or people's mental health needs required additional staffing. For example, on the day of our inspection a trip to Knaresborough had been planned. We found that additional staff were on duty to care for the people who chose not to go on the trip. Staff told us they felt there were enough staff to meet people's needs. Staff said, "Staffing levels are good. It is not very often that people phone in sick. We have never had a bad staffing level here", and, "People don't have to wait long for things."

There were systems in place to ensure that new staff were suitable to care for and support vulnerable adults. We viewed the recruitment records for six staff. We found the provider had requested and received references in respect of prospective new staff, including one from their most recent employment. A disclosure and barring service (DBS) check had been carried out before confirming any staff appointments to check that new staff members were suitable to work with vulnerable adults. Staff confirmed they had completed an application form when applying for their role and were appointed following a formal interview process.

We found that medication was usually administered appropriately. We looked at the medication administration records (MARs) for all people who used the service. We found one instance where there was a gap on a MAR where there was no signature or code used to confirm whether the medication had been given. We viewed the weekly medication audit for the relevant week and found that this had not been successful in identifying this gap in signatures. The audit record actually specified 'no gaps on MAR'. The registered manager told us the audit was usually completed accurately but she would speak with the staff member responsible for completing it.

People had specific care plans for 'as and when required' (PRN) medication. We found that one person had a specific care plan for PRN medication. However, evaluations of this care plan referred to a different medication. This meant that there was a risk that staff could become confused as to which medication the person usually took, which could lead to the person receiving incorrect medication.

Staff responsible for administering medication had completed safe handling of medicines training. We found that staff also maintained other records relating to medication such as medicines received and disposed of, fridge temperature checks and records relating to drugs liable to misuse (known as 'controlled drugs). People said they received their medication on time. One person said, "It's on time", and, another person said, "Yes, every morning, tea time and just after supper."

The provider had procedures to ensure that the premises were safe. Records showed that the provider undertook regular health and safety related checks of the premises. This included fire alarm testing, checks on fire fighting equipment and water temperature checks. The registered manager also kept a record of fire drills. We saw that the service had an emergency plan to ensure people's safety in the event of an emergency. We found this had recently been reviewed to make sure it was up to date and still relevant. We saw that a record was kept of any repairs and maintenance that was required. This detailed when the fault was reported and the action taken to resolve the issue. People who used the service did not use any specialist equipment.

The home had effective procedures to minimise and control the risk of infection. We saw that there were up to date policies and procedures for staff to refer to about infection control, such as hand hygiene and preventing the spread of infection. Staff had completed specific infection control training. The registered manager told us that a specialist nurse carried out this training. Staff gave us examples of how they had put their learning into practice. For example, regular hand washing and changing gloves and aprons for each task. They also told us that they encouraged and supported people to follow the same procedures when they helped out in the kitchen. We saw that information about infection control had been made available for people in an easy read and pictorial format. The registered manager monitored infection control by undertaking a random check on four staff each month. We

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Is the service safe?

viewed records of previous checks and found these were carried out consistently and no concerns had been identified. The registered manager also undertook an annual audit. We viewed the most recent audit and found the home had been 100% compliant. People we spoke with gave us positive feedback about cleanliness in the home. One person said, “It's clean enough, the beds are clean.” Another person said, “The bed linen smells of roses.”

Good

Is the service effective?

Our findings

Staff told us they were well supported to carry out their role. Staff said, “The manager is supportive of anything and doing qualifications. For example, I have just done diabetes training with the hospital”, and, “The manager encourages us to do training all the time.” We saw from viewing records that staff received regular supervision and appraisal. Appraisals were structured to encourage staff to think about how they cared for people. For example, when preparing for their appraisal staff were prompted to consider which parts of their job they did well, which parts were more difficult and any training and support needs they had. We saw that staff had personal development plans which identified any training and development needs they had.

People told us they felt the staff providing their care had the appropriate experience and skills. They said staff looked like they knew what they were doing. People commented, “Yes, they've all been here a long time, so I'd be very surprised if they didn't”, “Yes, they know what they're doing. They take me to town, bring me back and sit me in this chair”, and, “Yes, they're alright.”

Staff told us that people received appropriate support when they moved between different services. For example, they told us that when a person was going to hospital they were accompanied by staff. Staff said the hospital would be provided with important information, such as full copies of risk assessments, care plans and MARs. Staff told us they would stay with the person until they were settled and a formal handover had been done with the hospital staff. They said a member of staff would visit the hospital everyday to ensure the person was alright. One person said, “Yes, they're all good. They go to hospital with me every few months.”

We saw examples within people’s care records of involvement from various health professionals, such as the GP, dietitians and the ‘falls team.’ Staff undertook routine checks of people’s health. We saw from viewing people’s care records that staff routinely took the blood pressure of every person who used the service. However we found there was no explanation in people’s care records why this was being done. We also found that there was no guidance for staff to advise them what to do if a person’s blood pressure reading was abnormal.

We found no evidence in people’s care plans that nursing staff were using skills in psycho-social interventions (to treat or prevent using educational, behavioural and/or cognitive approaches) or of planned therapeutic interventions taking place. For example, group work, relaxation therapy and anxiety management. The staff at Seymour House supported people who have significant mental health needs. Therapeutic nursing interventions through on-going assessment and care planning have been shown to have a positive impact on people’s symptoms of mental distress, such as hallucinations, hearing distressing voices and reduced anxiety symptoms.

People were supported to meet their nutritional needs. We saw from viewing people’s care records that they were assessed for the risk of poor nutrition. Staff said that there was currently nobody identified as at risk of poor nutrition. They said they kept a ‘food chart’ for one person who had diabetes. Staff described the action they would take if a person was identified as being at risk, such as monitoring their food and fluid intake, offering supplements, supporting people with planned weight loss and providing dietary advice. Staff had a good understanding of people’s food likes and dislikes and ensured that they were offered things they liked to encourage them to eat. Staff told us how the service had been adapted and changed to support people’s nutritional needs. They said that some people were regularly missing their breakfast as they were not up in time. Staff said the breakfast time had been extended and 90% of people now had a breakfast.

People were happy with the food they received and gave us only positive comments. People said, “You get plenty to eat and plenty to drink”, “No complaints about the food”, “The food's very good, better than most places. We have gammon and ham shank with peppercorns and honey brushed on. On Sunday we have a traditional Sunday lunch, beef, Yorkshire pudding and two veg”, “I'm very contented with the food. Very pleased.” One person said, “They don't have much after 8.30pm at night.” We discussed this with the manager who confirmed that people were able to have something to eat if they wanted.

Good

Is the service caring?

Our findings

People said they were well cared for and that staff treated them well. People commented, “They're (staff) good, I've had no problem with them”, “The staff here are just people like us. They're very nice. You can't say any more than that”, “They're lovely”, “The staff are friendly and the residents are too”, “Fine, really good like”, “The staff have been good to me. Very good”, “They treat me fine”, and, “Yes, they look after me.”

People were treated with dignity and respect. Staff had a good understanding of the importance of maintaining people’s privacy and dignity. They gave us practical examples of how they delivered care to achieve this aim. For example, ensuring the door was locked when a person was using the toilet, encouraging people to pick out their own clothes and using toiletries people had chosen themselves. One staff member said, “I treat people with respect and make sure they don’t feel embarrassed and uncomfortable. I wouldn’t just do things my way.” We observed at one point that one person’s trousers were falling down. We saw that staff noticed this quickly and dealt with the situation discreetly without any fuss.

People told us they were treated equally and fairly. One person said, “It's been alright since I've been here. I've only been here a month, like.” Another person said, “I've never noticed anyone treating me unfairly.” We found that all staff had completed equality and diversity training as part of their core training requirements. The standards of service that people could expect had been documented into an ‘Expectation Card’ and made available to people. This included the expectation that staff would treat people as an equal and without discrimination and that staff would spend time listening and talking with people.

We observed that people looked cared for. Throughout our inspection we saw positive interactions between staff and people. Staff appeared to know people well and there was good rapport. People said, “They're lovely to me, very good. If you want a cup of tea and biscuits they bring them. I wouldn't like to leave anyway”, “Every time they have a birthday, they bake a cake and put a candle on”, and, “I think I've come on a lot since I've been here.”

We spoke with staff about the care they delivered to people and we particularly asked them to tell us what the service did best. They commented, “Meeting the needs of residents”, “Promoting independence. It’s like a home from home”, “Gives people somebody that actually cares about them. Most people don’t have family”, “We are good at supporting people to have rights and do what they want to do”, and, “We offer a very good standard of care, making sure the residents are happy all the time. We do everything to involve them and be involved with them.”

Staff told us that they were able to spend one to one time with people. They said they would usually spend this time sitting and chatting with people, looking through newspapers with them, shopping or sorting out clothes and toiletries. One staff member said, “We can give people the time they need”, and, “We can meet people’s choices quickly.” Another staff member said, “People have choice, it is all about them. It is about what they want as it is their home.” People confirmed that staff listened to them and most people said that staff gave them the time they needed without being rushed. One person said, “The staff listen to my opinions.”

People were supported to maintain their independence. We saw that people accessed the local community independently. Staff told us that they encouraged people to be independent and do things for themselves. One person said, “If a poorly patient needs cigarettes the staff will go out with them to the shop. It gives them confidence. One of the women now goes out on her own.”

We saw that information about advocacy services was displayed in communal areas of the home. Staff said the manager spoke with people about advocacy and how to access support. This meant people had access to information about how to access independent advice and support.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us that before a person was admitted into Seymour House, a multi-disciplinary meeting was held between health and social care professionals involved in their care. We saw that the referring agency provided the home with detailed information about each person's care needs. We viewed people's care records and found that the service carried out a pre-admission assessment. However, we found no evidence that following admission Seymour House staff carried out their own comprehensive, person-centred assessment of people's needs. This meant that it was not always clear how the needs identified in people's care plans had been determined.

We found that people's care had been planned around medical diagnoses rather than people's presenting needs. For example, paranoid schizophrenia, depression and anxiety. We saw that care plans did not describe the potential impact on the person and did not record their views about their condition. This meant care plans had not been written from the person's perspective and did not take account of how their diagnosis affected their daily life. The registered manager told us that they were already implementing a new format for care planning which would be more person centred.

We found that care plans were not written in a person-centred way. Staff told us that people were asked about how they wanted to receive their care and what their preferences were. However, care plans did not evidence that people who used the service had been involved in developing them. Care plans were written from a professional's perspective and used language and jargon that would make it difficult for people who used the service to understand. For example, one care plan used the terminology 'delusional beliefs with grandiose ideas and auditory hallucinations.' This language may not be clear to people or non-professionally registered care staff and could be a barrier to people becoming actively involved in planning their care. The registered manager was aware of the current limitations with care planning and had plans to implement a more person-centred approach to care planning. We found that one person had completed a 'spiritual care assessment.' This gave staff good insight into the person's aspirations.

Staff did not have access to sufficient information to ensure people received the most effective care for their particular needs. We saw from viewing care plans that limited interventions had been documented to support people. For example, one person's care plan identified that they had a 'disturbed sleep pattern.' The interventions recommended in the care plan to manage this situation only related to the administration of medicine. There was no description as to why the person may experience disturbed sleep or any other interventions that may help, such as establishing a nightly routine, offering reassurance and relaxation. Examples of interventions included in other people's care plans were general, such as 'liaise with health professionals' and 'give medications.' There were no specific instructions for staff about how to respond to people's individual needs.

It was difficult to measure whether people had made progress towards achieving their goals. We found that progress was difficult to measure due to the way care plans had been written. People's specific needs had not been documented and identified goals were general and not easily measured. For example, one person had been identified as having 'poor budgeting skills' and their identified goal was to 'improve budgeting skills.' We found that this care plan had been evaluated but there was no evidence as to how progress had been measured against any expected outcomes.

We found from viewing people's care records that staff kept a daily record of how each person had been that day. However, we found that the comments staff had recorded were not always meaningful and linked to people's care plans. For example, staff had recorded that one person had been 'pleasant and chatty' 15 times in 15 days. We found that care records and daily records were kept in separate files. This meant that it was not immediately obvious from the care records what the latest events for each person were.

Care records we viewed were not in line with recognised best practice. For example, polythene pockets were used for the care records, care records did not contain the person's name, records were not signed or initialled and did not have timed entries (Nursing and Midwifery Council Record keeping Guidance for nurses and midwives 2009). This meant that there was a risk that records could be misplaced and it would be difficult to return to the correct file.

Requires Improvement

Is the service responsive?

People had opportunities to give their views about the service. They told us staff held meetings for them so that they could share their views. We viewed the minutes from previous 'resident's meetings' and found that these were held monthly. We saw from the minutes that people actively took part in the meeting. People had given their views about recent trips they had been on and gave suggestions for future destinations for trips out. Following the meeting the minutes were placed on the notice board for people to read along with the manager's response to their feedback.

People were asked for their consent before receiving any care and support. Staff told us they always asked people what they would like before delivering any care. They said if a person said no they would accept their decision and would talk to them about the decision and try again later. One staff member said, "We can't force people." Staff said they would give people choices and offer alternatives. They told us they knew about people's preferences from speaking with them.

People had the opportunity to be involved in a range of activities. Staff gave us examples of the activities that were offered to people, such as trips out, the walking club, visiting family, card games, board games and entertainers.

We asked people to tell us about activities they could take part in. They said: "I like to read library books, listen to music and eat and drink"; "In the evenings we have a gentleman comes here and plays guitar and sings. Then there's (name) who comes and plays the organ for us"; "I like to have a chat"; "I like to listen to the radio"; "The night nurse comes in. She makes her own jam. She shows us how to do it and then she leaves the jam for us. She brings in all the ingredients in herself, at her own cost"; and, "We're entertained, go on trips, sometimes they'll take us to Whitby and have fish and chips. (The registered manager) paid for that I believe."

The registered manager told us there had been no formal complaints made about the service. However, the provider has a complaints procedure and a system to deal with any complaints received. People told us they were happy with their care and nobody raised any concerns or complaints with us during our inspection. People said, "At Christmas time they'll put on nibbles. You can't complain really", "It's lovely in here. Nice and warm when the sun shines. I wouldn't like to go anywhere else", and, "It's all been good." Staff told us that people would complain if they were unhappy. One staff member said, "The people are brutal with the truth and forthcoming with their views."

Good

Is the service well-led?

Our findings

The values of the service were not fully embedded into service delivery. The service had specific values to work towards. Staff told us that they were aware of these values but were unable to tell us what they were. For example, one staff member said, “Values, yes but I can’t think what they are.” The service had an over-arching five year plan. This included specific objectives which included providing a well-trained, skilled staff team and promoting excellence in care practices.

The home had a clear management structure. Staff said, “The manager is very approachable and the team is supportive.” The registered manager told us that her “door was open every day.” She told us that the team were very good at supporting each other. The registered manager said, “The staff are a very caring and together team and treat each other with respect.” Staff we spoke with mirrored the manager’s comments. They said, “Nothing is ever a problem for her (the registered manager), if you need anything you will get it. She is the best boss I ever had”, and, “The nurses are brilliant. Nothing was a problem if I asked anything.”

Staff had the opportunity to give their views about the service including making suggestions to improve the service. We asked staff to tell us about how they were encouraged to give feedback about the service. One staff member said, “During staff meetings or on a daily basis, anytime anybody can think of anything. It is free for all to input and it is encouraged.” Staff gave us examples of changes that had been made following their suggestion, such as new menus, changing the seating arrangements in communal areas and a new procedure for doing laundry. We viewed the minutes from previous staff meetings which showed that these had been held regularly. We found that staff meetings were used as an opportunity to raise staff awareness of important information and to identify learning opportunities. For example, MCA and DoLS was discussed at the last staff meeting. During a previous meeting the theme was infection control which included reinforcing effective practices to reduce the risk of infection, such as hand washing techniques.

People mostly made positive comments about the atmosphere in the home. They said: “This is the friendliest place I've been”; “I like loads of people in here. I have no problems, just falling over all the time”; “Lovely. It's a good place. I wouldn't like to change anything”; “Since I've come here I've found a lot of contentment”; and, “It's alright.” One person told us that there could sometimes be a bit of tension between some of the people who used the service.

The registered manager undertook a range of audits to ensure the quality of care being delivered. We viewed the most recent six monthly ‘Standard of Care Quality’ audit which had been carried out in June 2014. We saw the audit looked at premises, management, care of people, staffing and included the views of people and staff. Feedback from people and staff during the last audit was all positive. Areas of improvement had been identified, such as re-developing the menu with input from people who used the service. Other checks were undertaken such as a supervision audit, infection control and medication audits. The registered manager told us that she walked round the building and spoke with people regularly and encouraged them to give feedback. She said she would also observe the care that was being delivered and how staff were treating people. For example, were they giving people eye contact when delivering care.

The provider had policies and procedures in place to respond to any whistle blowing concerns. Information about whistle blowing was contained in the staff handbook. Staff we spoke with knew how to report any concerns they had and said they would use the procedure if they needed to. Staff said, “The manager would act on concerns straightaway. She would not tolerate it”, “The manager is very good. She deals with things straightaway as they happen. The manager does far more than she should”, and, “The manager would act straightaway.”

There were systems to log any incidents and accidents that happened at the service. The service had an up to date policy and ‘flowchart’ for staff to refer to if they needed guidance about how to deal with incidents or accidents. We viewed the home’s log and found that details of incidents and accidents had been recorded appropriately including details of any action taken following an incident. For example, one person who had fallen had been checked for injuries and monitored until staff were happy they were alright. The registered manager used the information available to look for trends and patterns. For example, one person who had fallen three times had been referred to the

Good

Is the service well-led?

'falls team' for specialist advice and guidance. This meant information was analysed and action taken to prevent incidents from happening again in order to keep people safe.